# GNMI MRI & CT MEDICAL IMAGING

❐ MISSISSAUGA
❐ AJAX

**FREE PARKING**
Phone: (905) 568-3768
Fax: (905) 568-0941
www.gnmi.ca info@gnmi.ca

Patient First Name | Patient Last Name | Referring Physician Name

Home Phone | Cell Phone | Phone | Fax

OHIP# | Version Code | Sex M | F | DD / MM / YYYY Date of Birth | DD / MM / YYYY Date

❐ Non-OHIP/Third-party
❐ WSIB Claim # ____________ Injury Date DD / MM / YYYY Company Name ____________ Phone ____________

DD / MM / YYYY
Appointment Date | Appointment Time

24-hour notice required to cancel appointment or $75 charge billed.

Is patient able to come in on short notice? ❐ YES ❐ NO

Patient consents to appointment information being disclosed in a telephone message? ❐ YES ❐ NO

## CLINICAL HISTORY – EXAM REQUESTED *(Please be specific)*

❐ CT ❐ MRI

Doctor's Signature ____________ Copy To: ____________

## FOR CT PATIENTS

| | YES | NO |
|---|---|---|
| Does patient have a history of kidney disease? (e.g., one kidney, renal failure, dialysis) | ❐ | ❐ |
| Is patient diabetic? | ❐ | ❐ |
| Previous reaction to IV contrast? | ❐ | ❐ |
| Is patient taking Metformin or Glucophage? | ❐ | ❐ |

Please list known allergies:

____________

## FOR MRI PATIENTS (To be completed with patient)

| | YES | NO |
|---|---|---|
| Have you had a previous MRI? | ❐ | ❐ |
| Has metal ever gone into your eye? | ❐ | ❐ |
| Do you have any kidney disease? | ❐ | ❐ |
| Are you on dialysis? | ❐ | ❐ |
| Are you claustrophobic? | ❐ | ❐ |
| Allergy to gadolinium contrast? | ❐ | ❐ |

Do you have any of the following:

| | YES | NO |
|---|---|---|
| Aneurysm Clips | ❐ | ❐ |
| Artificial Cardiac Valve | ❐ | ❐ |
| Cardiac Pacemaker | ❐ | ❐ |
| Cochlear Implants | ❐ | ❐ |
| Coil/Stents | ❐ | ❐ |
| Neurostimulator | ❐ | ❐ |
| Retained Pacing Wires | ❐ | ❐ |
| Shrapnel/Bullets | ❐ | ❐ |

Other implanted devices ____________

If YES to any, please specify (date, type, implant model):

____________

## PREVIOUS RELEVANT EXAMS

Please provide all previous reports with requisition
Please state **when** and **where** for each exam

None ❐
MRI ❐ ____________
CT ❐ ____________
X-ray ❐ ____________
Ultrasound ❐ ____________
Nuclear Medicine ❐ ____________

## LIST ALL SURGERY

Please list all surgeries and specify a date and type.
Please provide all surgical reports with requisition.

DD / MM / YYYY ____________

DD / MM / YYYY ____________

Most recent Creatinine/GFR levels within 3 mos:

Creatinine ________ GFR ________

Date DD / MM / YYYY

Date of last menstrual cycle

Date DD / MM / YYYY

Weight ______ Height ______

## ULTRASOUND *(Mississauga site only)*

❐ ULTRASOUND *(By Appointment)* ____________

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: **http://www.health.gov.ca/en/public/programs/ihf/facilities.aspx**

**FAX COMPLETED REQUISITIONS TO: (905)-568-0941**
Patient will be directly contacted to schedule an appointment

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## PATIENT INFORMATION

ARRIVE AT LEAST 30 MINUTES BEFORE YOUR APPOINTMENT UNLESS OTHERWISE SPECIFIED. LATE APPOINTMENTS MAY BE REBOOKED.

### FOR PATIENTS WITH KNOWN ALLERGIES AND CLAUSTROPHOBIA

If the patient has a known contrast allergy, the requesting physician is responsible for organizing the pre-medication prior to the patient's scan.
Contrast allergy premedication: Prednisone 50mg P.O. 13 hours and 1 hour pre-examination plus Benadryl 50mg P.O. 1 hour pre-examination.
If the patient has claustrophobia, the requesting physician is responsible for organizing the sedation.

**NOTE:** Benadryl and oral sedation can cause drowsiness. Patients should make arrangements to be driven from the examination.

**IT IS CRITICAL FOR PATIENT SAFETY THAT ALL RELEVANT SECTIONS ON THE FRONT OF THE REQUISITION ARE COMPLETED BY THE REFERRING PHYSICIAN. INCOMPLETE REQUISITIONS WILL BE SENT BACK FOR COMPLETION.**

## CT STUDIES

### CHEST/BODY

Chest
PE Chest
Pulmonary Nodule-Low Dose
Hi-Res Chest
CTA Chest Dissection
Abdomen & Pelvis
Pelvis
Renal Colic
Urogram
Renal Mass
Liver
Pancreas
Adrenal Gland
Bony Pelvis
CTA Chest-Abdomen-Pelvis
CTA Abdomen-Pelvis
CTA Mesenteric
CTA Runoff

### SPINE

CT Cervical
CT Thoracic
CT Lumbar
CT SI Joints
CT Sacrum/Coccyx

### HEAD/NECK

Brain
CTA Head
CTA Head & Neck
CTA Neck
Circle of Willis
Carotids
CT Venogram
Soft Tissue Neck
Orbits
Facial Bone
TMJ
Sinuses
Temporal Bones

### EXTREMITIES

Shoulder
Humerus
Scapula
Elbow/Forearm
Wrist/Hand
Hip
Femur
Knee
Tib/Fib
Ankle/Foot

## MRI STUDIES

### HEAD/NECK

Brain
Demyelination
IAC
Dementia
Concussion Protocol
Pituitary Gland/Sella
TMJ
Pineal Gland
Orbits
Seizure
Cranial Nerve
Trigeminal Neuralgia
Soft Tissue Neck
Skull Base
Cavernous Sinus
Face/Sinus

### MRA/MRV

MRA Head Circle of Willis
MRA Neck Carotids
MRV Dural Venous Sinuses
Renal Arteries
Aorta

### MSK

Shoulder
Humerus
Scapula
Elbow
Forearm
Wrist
Hand/Fingers
Thumb
Hip
Femur/Thigh
Knee
Tib-Fib/Calf
Ankle
Foot
Chest
Pectoralis
Brachial Plexus
Sports Hernia
Ortho Pelvis
Sternum
SC Joints

### SPINE

Cervical
Thoracic
Lumbar
SI Joints
Sacrum/Coccyx

### ABDOMEN/PELVIS

Abdomen
Liver
MRCP
Pancreas
Kidneys
Adrenals
Female Pelvis
Male Pelvis
Rectum
Anal Fistula

*Please note that all studies are protocolled by the radiologist based on the clinical information provided and patient history

## LOCATIONS FOR CT OR MRI SERVICES

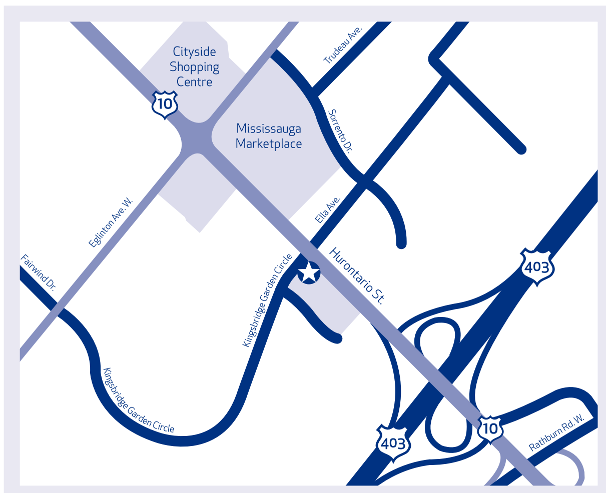
### MISSISSAUGA

The Emerald Centre
10 Kingsbridge Garden Circle
Phone: 905-568-3768
Fax: 905-568-0941

CT | MRI | ULTRASOUND
FREE PARKING

**DIRECTIONS FROM TORONTO**

401 W
Exit Hwy 403 (QEW/Hamilton)
North on Hurontario St.
Left on Kingsbridge Garden Circle
Left on Tucana Crt
Left into driveway




### AJAX

Harwood Plaza
300 Harwood Ave South
Phone: 905-426-8976
Fax: 905-426-5234

CT | MRI
FREE PARKING

**DIRECTIONS FROM TORONTO**

401 E
Exit Westney Rd S
Left (east) on Bayly Ave
Left (north) on Harwood Ave
Left into Harwood Plaza (located beside Tim Hortons)